STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS COMPLAINT #: 2575153 CENSUS: 88 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		09/16/2025
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Complaint #:2575153 Based on observation, interviews, medical record review, and review of pertinent facility documents, it was determined that the facility failed to administer medications with less than a 5% medication error rate. The surveyor observed one nurse administer medications to four residents with a total of 43 opportunities. Three errors were observed, which calculated to a medication administration error rate of 6.97%. This deficient practice was identified for two of four residents that were administered medications by 1 nurse on the[redacted] unit. This deficient practice was evidenced by the following:	F0759	The unsampled resident was given the correct medication. The attending physician for the unsampled resident was notified that the resident had [redacted] instead of [redacted] and no new orders were received. RN# 1 who was involved with the cited practices was provided with one on one re- education on 8/1/25 by the Director of Nursing regarding proper medication administration, with emphasis on following the 5 rights of medication administration to avoid medication errors. Same nurse was med passed by the Unit Manager (UM) on 8/5/2025. All residents have the potential to be affected by this deficient practice. A facility wide in-service was started on 8/2/25 by the Director of Nursing with the licensed nurses on proper medication administration and ensuring the 5 rights are followed (right resident, right dose, right route, right medication and right time). Medication Pass competencies was started by the Director of Nursing and licensed nurse supervisor on 8/2/2025 and will be ongoing until all licensed nurses are completed. The same in-service and med pass competencies will be given during orientation for newly hired nurses, annually and as deemed necessary.	09/16/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0759 SS = E	Continued from page 1 1.) On 08/01/2025 at 8:45 A.M., the surveyor observed the Registered Nurse (RN #1) preparing and administering medications for an unsampled resident. RN #1 removed a jar labeled as NJ Exec Order 26.4b1 [redacted] tablets from the medication cart and poured one tablet into the medication cup with the other medications being prepared for the resident. RN #1 continued to prepare the resident's medication. At that time the surveyor observed the physician's order (PO) for NJ Exec Order 26.4b1 indicated to administer one NJ Exec Order 2 tablet, not a NJ Exec Order 2. The surveyor stopped RN #1 to confirm that she was finished preparing medication for the resident and was prepared to administer them. RN #1 reviewed the NJ Exec Order 26.4 order and stated, "I didn't notice that." The RN obtained NJ Exec Order 2 tablets for administration to the resident. (error #1) During the same medication preparation and administration observation, the surveyor observed RN #1 place two NJ Exec Order 26.4b1 [redacted]) NJ Exec Order 26.4 NJ Exec Order 2 tablets into the medication cup with other medications being prepared for the unsampled resident. The NJ Exec Order 26.4 tablets were administered to the resident with their other medications and NJ Exec Order 26.4b by the resident without being NJ Exec Order 2 RN #1 confirmed that the NJ Exec Order 26.4b1 tablets were NJ Exec Order 26.4b along with the resident's other medications without being NJ Exec Order 2 (error #2) A review of the unsampled resident's Admission Record (AR) revealed that the resident was admitted with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted] The most recent Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, was reviewed. The MDS revealed that the resident had a brief interview for mental status (BIMS) score of NJ E out of 15, indicating that the resident's NJ Exec Order 26 was NJ Exec Order 26.4b1. A review of the resident's physician orders POs revealed the following orders:	F0759	Continued from page 1 Facility Pharmacist and/or the Director of Nursing and/or license nurse supervisor will perform weekly med-pass competencies for 2 licensed nurses covering all shifts x 4 weeks and then monthly x 6 months. Negative findings will be addressed immediately through one on one re-in-service and additional med pass competencies by the Director of Nursing and/or the facility pharmacist and/or the licensed nurse supervisor until no medication errors are observed. Results of the med passes will be submitted and reviewed at the Quality Assessment Assurance (QAA) committee who meets quarterly and will determine further necessity of audits and recommendations.	

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F0759 SS = E	Continued from page 2 NJ Exec Order 26.4b1 ; give 1 tablet by mouth two times a day for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ; give 2 tablets by mouth two times a day for NJ Exec Order 26.4b1 2.) On 08/01/2025 at 10:00 A.M., the surveyor observed RN #1 prepare Resident #1's medications for administration. The surveyor observed RN #1 pour NJ E for administration to Resident #1. At that time the surveyor observed the PO for NJ Exec Order 26 which indicated to administer NJ Exec Order 26.4b1. The surveyor stopped the RN #1 and confirmed that she was finished preparing medication for the resident and was prepared to administer them. RN #1 reviewed the NJ Exec Order 26 order and confirmed that NJ Exec Or was ordered. RN #1 poured NJ Exec Orde of NJ Exec Order 26.4 and administered it to Resident #1 with the resident's other medications. (error #3) A review of the Resident #1's AR revealed that the resident was admitted with diagnoses including but not limited to NJ Exec Order 26.4b1). Resident #1's most recent MDS dated NJ Exec Order 26.4b1, was reviewed. The MDS revealed that the resident had a BIMS score of NJ E out of 15, indicating that the resident's NJ Exec Order 26 was NJ Exec Or The MDS further revealed that the resident was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b on a NJ Exec Orde for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of Resident #1's POs revealed the following order: NJ Exec Order 26.4b1 by	F0759		

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F0759 SS = E	Continued from page 3 mouth three times a day for [redacted] An interview was conducted with RN #1 on 08/01/2025 at 1:40 P.M. RN #1 confirmed that she was prepared to administer [redacted] to the unsampled resident and [redacted] to Resident #1. RN #1 stated that she was unsure if the unsampled resident's [redacted] should have been [redacted] RN #1 confirmed that the resident [redacted] the [redacted] without [redacted] it. During the same interview, RN #1 stated that medications should have been administered ensuring: the right resident, right dose, right route, right medication, and right time. RN #1 stated that the process was to make sure that the right medication and dose were taken out for each resident, then to identify the resident, then to ensure that the resident took those medications. RN #1 stated that the process needed to be followed to make sure that residents received the treatments they needed. RN #1 further stated that if a resident received the wrong medication, and depending on the medication received, the resident could die. An interview was conducted with Unit Manager (UM #1) on 08/01/2025 at 3:02 P.M. UM #1 stated that the expectation was that medications were given following the rights of medication administration, facility policies, and physician orders. UM #1 further stated that if medications were not administered according to facility policies and her expectations, that harm could be caused to a resident and, "that's the last thing we want." An interview was conducted with the [redacted] on 08/01/2025 at 3:46 P.M. The [redacted] stated that the expectation every time medication was administered was that it was done according to the facility medication administration policy and the five rights of medication administration. The [redacted] stated that the issues identified during that morning's medication administration observation did not meet her expectations for medication administration. The [redacted] further stated that if medications were not administered according to the facility policy and the five rights of medication administration, the consequences to the resident could range from sneezing to death.	F0759		

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F0759 SS = E	Continued from page 4 A review of the facility's, "Medication Administration" policy with a reviewed date of 1/2025 revealed under, "Policy Explanation and Compliance Guidelines;" "[…]11. Compare medication source (bubble pack, vial, etc.) with EMAR [electronic medication administration record] to verify resident name, medication name, form, dose, route, and time […] 14. Administer medication as ordered in accordance with manufacturer specifications." NJAC 8:39-11.2(b)	F0759		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2575153 Based on interviews, record review, and review of other pertinent facility documents on 08/01/2025, it was determined that the facility failed to ensure that a resident (Resident #2) received the correct NJ Exec Order 26.4b1 [redacted] This deficient practice was identified for one of three residents reviewed for medication errors and was evidenced by the following: According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted] According to the most recent Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 Resident #2 had a Brief Interview of Mental Status score of [redacted] out of 15,	F0760	1. The medication error for resident #2 was identified almost immediately and was corrected by same nurse who was involved in the cited practice. The physician for resident #2 was notified at the time of the incident with no new orders. The resident was monitored for any sign or symptoms of NJ Exec Order 26 and no NJ Exec Order 26.4b1 was identified. RN # 2 was re- educated by the Nursing Supervisor on 7/26/2025 and the Director of Nursing (DON) on 7/28/2025 regarding proper medication administration and ensuring the 5 rights are followed (right resident, right dose, right route, right medication and right time) and with emphasis of preparing NJ Exec Order 26.4b1 [redacted] medication for one resident at a time and not to retrieve NJ Exec Order 26.4b1 from the medication room to avoid medication administration errors. Same licensed nurse was med passed by the Unit Manager on 7/27/2025 to check the licensed nurse skill competencies in medication administration with emphasis on NJ Exec Order 26.4b1 administration. 2. All residents who have a physician's order for IV antibiotic medications have the potential to be affected by this deficient practice. An audit was done on 7/26/25 to ensure that no other resident received the wrong IV and all other IV counts were correct. 3. A facility wide in-service was started on 7/28/2025 and repeated 8/2/25 with licensed nurses on proper medication administration and ensuring the 5 rights are followed (right resident, right dose, right route, right medication and right time) with emphasis of preparing Intravenous (IV) Antibiotic medication for one resident at a time and not to retrieve multiple IV medication bags from the medication room to avoid medication administration errors. IV medication administration skill competencies were initiated by the	09/16/2025

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F0760 SS = D	Continued from page 5 which indicated the resident's NJ Exec Order 26.4b1. A review of the facility incident report dated NJ Exec Order 26.4b1 at 6:26 P.M., was conducted. Under, "Incident Description," the document revealed the following: "Nursing Description: [Resident #2] received NJ Exec Order 26.4b1] instead of the ordered NJ Exec Order 26.4b1]. Resident admitted to this facility on NJ Exec Order 26.4 after a NJ Exec Order 26 at NJ Exec Order name] to complete NJ Exec Order 26.4b1 for NJ Exec Order 26 " A facility "Witness Statement," document from RN #2 with the date NJ Exec Orde with a NJ E written over the N was reviewed. The statement revealed that at 6:00 P.M., RN #2 brought two bags of NJ Exec Order 26.4b1 into Resident #2's room, one belonged to Resident #2 and the other belonged to a different resident. RN #2 began the administration of NJ Exec Or which belonged to another resident instead of the NJ Exec Order 26.4b1 which was the NJ E prescribed to Resident #2. The statement further revealed that RN #2 noticed the error and stopped the NJ Exec Order 26.4b1 in less than three minutes. The physician was notified, and the resident was monitored for signs of complication. Resident #2 was NJ Exec Order 26 at the facility. A closed record review was conducted. A review of the "Order Summary Report (OSR)," for Resident #2 revealed the following physician order (PO): 'NJ Exec Order 26.4b1 one time a day for NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1 23:59 [11:59 P.M.]." The order had a start date of NJ Exec Order 26.4b1 and an end date of NJ Exec Order 26.4b1 A further review of the OSR revealed no POs for NJ Exec Or for Resident #2. A telephone interview was conducted with RN #2 on 08/01/2025 at 12:53 P.M. RN #2 stated that the medication administration process included verification	F0760	Continued from page 5 Director of Nursing on 7/28/2025 and will continue until all licensed nurses are completed. Same in-service education and medication administration skill competencies with emphasis on IV medication administration will be given during orientation of a newly hired licensed nurse, annually and as deemed necessary. 4. Facility Pharmacist and/or the Director of Nursing and/or license nurse supervisor will perform weekly med-pass competencies for 2 licensed nurses covering all shifts x 4 weeks and then monthly x 6 months. Negative findings will be addressed immediately through one on one re-in-service and additional med pass competencies by the Director of Nursing and/or the facility pharmacist and/or the licensed nurse supervisor until no medication errors are observed. The Director of Nursing and/or licensed nurse designee will check weekly for 2 residents who have physician order for IV medication administration to assure that the medications are correct in accordance with the physician's order. Negative findings shall be reported to the Director of Nursing immediately, and will be addressed through one on one re-service education and or progressive disciplinary measures as appropriate by the DON. Results of the med passes will be submitted and reviewed at the Quality Assessment Assurance (QAA) committee, who meets quarterly and will determine further necessity of audits and recommendations.	

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F0760 SS = D	Continued from page 6 of the resident's name, medication dose, medication route, and documentation. RN #2 stated that on [redacted] he gave the NJ Exec Order 26.4b1 to Resident #2. RN #2 stated that he brought two medications into Resident #2's room (one for Resident #2, and one for a resident in another room). RN #2 stated that he administered [redacted] instead of [redacted] to Resident #2. RN #2 stated that prior to administering the medication, he verified Resident #2's identity but not the medication he was giving. RN #2 stated that he noticed the error as soon as he left the resident's room, which was in less than one minute. RN #2 further stated that following the rights of medication administration was important for preventing errors and that medication errors could cause allergy, itching, or diarrhea depending on the medication. An interview was conducted with the Unit Manager (UM #1) on 08/01/2025 at 3:02 P.M. UM #1 stated that the expectation was that medications were given following the rights of medication administration, facility policies, and physician orders. UM #1 further stated that if medications were not administered according to facility policies and her expectations, harm could be caused to a resident and, "that's the last thing we want." An interview was conducted with US FOIA (b)(6) [redacted] on 08/01/2025 at 3:46 P.M. The [redacted] stated that the expectation every time medication was administered was that it was done according to the facility medication administration policy and the five rights of medication administration. The [redacted] stated that when the [redacted] was administered to Resident #2, the five rights of medication administration were not followed. The [redacted] further stated that if medications were not administered according to the facility policy and the five rights of medication administration, the consequences to the resident could range from sneezing to death. A review of the facility's, "Medication Administration" policy with a reviewed date of 1/2025 revealed under, "Policy Explanation and Compliance Guidelines;" "…10. Review EMAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with EMAR [electronic medication administration record] to verify resident name, medication name, form, dose, route, and time […] 14. Administer medication as ordered in accordance with manufacturer specifications."	F0760		

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F0760 SS = D	Continued from page 7 NJAC 8:39-29.2 (d)	F0760		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F0880	1. Resident #1 is no longer a resident in the facility. RN Nurse #1 was in-serviced on 8/1/25 by the Director of Nursing on facility Hand Hygiene policy and proper Infection Control techniques for administering [redacted]. Resident #2 [redacted] was discarded and replaced, and the [redacted] was wiped down and disinfected with appropriate disinfectant by the nurse Unit Manager on 8/1/25. RN# 1 was provided with one on one re-education and competencies on 8/5/2025 by the Director of Nursing regarding Infection Control practices with emphasis on following appropriate Infection Control practices when administering [redacted] with residents on [redacted]. 2. All residents who require Enhance Barrier Precautions and Transmission Based Precautions have the potential to be affected by this deficient practice. 3. A facility wide in-service education and competencies for licensed nurses was started on 8/2/25 by the Director of Nursing regarding appropriate Infection Control practices during medication administration specific on IV medication administration to ensure compliance with facility infection control policy. Same in-service education and competencies will be given on orientation for newly hired license nurses, annually and as deemed necessary. 4. Facility Infection Preventionist and/or Nurse Supervisor will conduct weekly random observations of 2 nurses covering all shifts during IV medication administration for residents who require Transmission Based precautions x 1 month and then monthly for 4 months to ensure that nurses are following appropriate Infection Control practices in accordance with the facility Infection Control policy. Negative findings shall be addressed by the facility Infection Preventionist (IP) through one on one re-in-service education with progressive disciplinary measures as appropriate. Results of the med passes will be submitted and reviewed at the Quality Assessment Assurance (QAA) committee, who meets quarterly and will determine further necessity of audits and recommendations.	09/16/2025

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F0880 SS = D	Continued from page 8 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2575153 Based on observation, interviews, record review, and review of other pertinent facility documents it was determined that the facility failed to maintain appropriate infection control practices during medication administration in accordance with in nationally accepted guidelines for infection prevention and control and the facility's policies and procedures. This deficient practice was identified for 2 of 2 residents (Resident #1 and Resident #2) reviewed for infection prevention and was evidenced by the following: 1. A facility incident report dated 07/26/2025 at 6:26 P.M., was reviewed. Under, "Incident Description," the document revealed the following: "Nursing Description: [Resident #2] received [NJ Exec Order 26.4b1] instead of the ordered [NJ Exec Order 26.4b1]. [Resident #2] admitted to this facility on [NJ Exec Order 26.4b] after a [NJ Exec Order 26.4b1]	F0880		

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F0880 SS = D	Continued from page 9 NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 A facility "Witness Statement," document written by the Registered Nurse (RN #2) with the date NJ Exec Orde with a NJ E written over the NJ Exec Or was reviewed. The statement revealed that at 6:00 P.M., RN #2 brought two bags of NJ E medication into Resident #2's room, one belonged to Resident #2 and the other belonged to a different resident. RN #2 then administered another resident's NJ E NJ Exec Order 26 to Resident #2. Resident #2 was NJ Exec Order 26.4 at the facility. A closed record review was conducted. According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses included but were not limited to: NJ Exec Order 26.4b1). According to the most recent Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident #2 had a Brief Interview of Mental Status score of NJ E out of 15, which indicated the resident's NJ Exec Order 26 was NJ Exec Or A review of the "Order Summary Report (OSR)," for Resident #2 revealed the following physician orders (POs): Maintain NJ Exec Order 26.4b1 due to NJ Exec Orde every shift for NJ Exec Order 26.4b1. The order start date was NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 . The order start date was NJ Exec Order 26.4b1	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 10 NJ Exec Order 26.4b1 Use NJ Exec Orde one time a day until NJ Exec Order 26.4b1 11:59 P.M. The order had a start date of NJ Exec Order 26.4b1 and an end date of NJ Exec Order 26.4b1. A review of the Care Plan (CP) for Resident #2 revealed a "Focus," that the resident required NJ Exec Order 26.4b1 related to a NJ Exec Order a NJ Exec Orde , and NJ Exec Orde Interventions included but were not limited to: clear signage posted on or near the room door; good hand hygiene when entering or leaving the room; and maintaining NJ Exec for the duration of the stay, until NJ Exec Order 26.4b1 The CP for Resident #2 also included a "Focus," that the resident had NJ Exec Order 26.4b1. Interventions included but were not limited to: observation of standard NJ Exec Order 26.4b1 (minimum set of interventions considered standards of care that prevent the NJ Exec Order 26.4b1); thorough cleaning of resident areas using disinfectants; and cleaning, disinfecting or sterilizing resident care equipment. A telephone interview was conducted with RN #2 on 08/01/2025 at 12:53 P.M. RN#2 stated that on NJ Exec Order 26.4b1 he brought two bags containing NJ Exec Order 26.4b1 medications into Resident #2's room (one for Resident #2, and one for a resident in another room). RN #2 stated that he then administered NJ Exec Orde instead of NJ Exec Order 26.4b1 to Resident #2. 2.) A medication administration observation was conducted on 08/01/2025 at 10:13 A.M. The surveyor observed RN #1 during the administration of NJ E to Resident #1. After exiting the room RN #1 returned wearing gloves that she touched the door and door handle with. RN #1 wearing the same gloves that she touched the door handle with then removed an empty NJ Exec Order 26.4b1 from the NJ Exec Order 2 and NJ Exec O the new medication. RN #1 then set the NJ Exec Order 26 and NJ Exec Order 26.4b the NJ Exec Order 26.4b1 to Resident #1's NJ Exec Orde while wearing the same gloves. A review of Resident #1's AR revealed that the resident was admitted with diagnoses that included but were not limited to NJ Exec Order 26.4b1	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

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F0880 SS = D	Continued from page 11 ([redacted]). Resident #1's most recent MDS dated [redacted], was reviewed. The MDS revealed that the resident had a BIMS score of [redacted] out of 15, indicating that the resident's [redacted]. The MDS further revealed that the resident had [redacted] on admission to the facility. A review of Resident #1's OSR revealed the following PO: Maintain [redacted] due to [redacted] every shift. Every shift for [redacted] The order start date was [redacted]. A review of the CP for Resident #1 revealed a "Focus," that the resident required [redacted] related to the presence of an [redacted]. Interventions included but were not limited to maintaining [redacted] for the duration of the stay, until [redacted], or removal of the [redacted]. Interventions also included "Educate and encourage good hand hygiene before entering and when leaving the room." The CP for Resident #1 also included a "Focus," that the resident had a [redacted] for the administration of [redacted] medication. Interventions included but were not limited to, "Perform hand hygiene before and after access with [redacted] An interview was conducted with RN #1 on 08/01/2025 at 1:40 P.M. RN#1 stated that during medication administration observation that morning she touched items in the room including the [redacted] then touched the resident's [redacted] without washing her hands and changing gloves. An interview was conducted with the Unit Manager (UM #1) on 08/01/2025 at 3:02 P.M. UM #1 stated that the expectation was that nurses followed the rights of medication administration and good infection prevention (IP) practices during medication administration. The expectation was that nurses washed their hands and changed gloves prior to touching a resident's [redacted] if	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

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F0880 SS = D	Continued from page 12 other items were touched first. UM #1 stated that touching other patient care items and then touching a resident's [NJ Exec O] did not meet her expectations for good IP practices. UM #1 stated that facility staff received continuing education on IP regularly. UM #1 further stated that if good IP practices were not followed patient harm or infections could occur. The facility's [US FOIA (b)(6)] was not available for an interview. An interview was conducted with [US FOIA (b)(6)] on 08/01/2025 at 3:46 P.M. The [US FOIA (b)(6)] stated that the expectation was for [NJ Exec O] and good IP practices to be followed for resident care. The [US FOIA (b)(6)] stated that RN #1 taking medications for another resident into Resident #2's room was against the facility's IP and [NJ Exec O] policies. The [US FOIA (b)(6)] stated that following good IP practices was important because the facility had a [NJ Exec Order 26.4b1] that was [NJ Exec Order 26.4b1] to make sure staff was safe, and to prevent any transmissions. The [US FOIA (b)(6)] further stated that the [US FOIA (b)(6)] UMs, [US FOIA (b)(6)] and Human Resources were responsible to ensure that IP practices were maintained in the facility. The facility's "Hand Hygiene," policy with a created date of 8/10/24 was reviewed. The policy revealed under, "Policy:" "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility." Under, "Policy Explanation and Compliance Guidelines:" the policy revealed, "1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. […] 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves." The facility's "Medication Administration," policy with a created date of 1/2025 was reviewed. The policy revealed under, "Policy Explanation and Compliance Guidelines:" "[…] 4. Wash hands/sanitize prior to administering medication per facility protocol and product." NJAC 8:39-19.4 (a) (1) (n)	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0880 SS = D		F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0000	INITIAL COMMENTS Revisit survey completed.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE